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Ethnographic Perspectives on Global Mental Health

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Abstract

The field of Global Mental Health (GMH) aims to influence mental health policy and practice worldwide, with a focus on human rights and access to care. There have been important achievements, but GMH has also been the focus of scholarly controversies arising from political, cultural and pragmatic critiques. These debates have become increasingly polarized, giving rise to a need for more dialogue and experience-near research to inform theorizing. Ethnography has much to offer in this respect. This paper frames and introduces five articles in the issue of *Transcultural Psychiatry* that illustrate the role of ethnographic methods in understanding the effects and implications of the field of global mental health on mental health policy and practice. The papers include ethnographies from South Africa, India and Tonga, that show the potential for ethnographic evidence to inform GMH projects. These studies provide nuanced conceptualizations of GMH's varied manifestations across different settings, the diverse ways that GMH's achievements can be evaluated, and the connections that can be drawn between locally observed experiences and wider historical, political and social phenomena. Ethnography can provide a basis for constructive dialogue between those engaged in developing and implementing GMH interventions and those critical of some of its approaches.

Key words: global mental health, cultural psychiatry, research methods, ethnography, evidence,

Introduction

In recent years, the field of global mental health (GMH) has aimed to become a major influence on mental health policy and practice in many parts of the world. It encompasses a collection of related initiatives that advocate for evidence-based strategies to 'scale up' services primarily in low- and middle-income countries, with a dual focus on improving both the human rights of people with mental health difficulties and access to mental health care worldwide. The importance of GMH is underscored by quantitative and qualitative data that point to the high burden of mental health problems both for individuals and caregivers, exacerbated by the lack of appropriate and accessible services in many parts of the world (Kleinman, 2009). Significant drivers of GMH include the WHO's series of monitoring reports and treatment recommendations, an international series on GMH commissioned by *The Lancet* and a linked Call for Action on Global Mental Health (Lancet Global Mental Health Group, 2007), the Grand Challenges in Global Mental Health Initiative (Collins et al., 2011) and the participatory network of the Movement for Global Mental Health (Patel et al, 2011). The support of such influential institutions and the humanitarian power of GMH's appeals have made important contributions in some countries in advancing human rights and extending mental health care.

This issue of *Transcultural Psychiatry* brings together five papers that highlight the role of ethnographic methods in understanding the effects and implications of such agendas for global mental health. A central aim of this collection of papers is to explore the potential contributions that ethnographic evidence might make to both understanding GMH as a field and informing its projects. This aim assumes importance in the context of two aspects of global mental health. First, debates in the field have become unnecessarily polarized (c.f. Bemme & D'souza,

2014; Cooper, 2016). This divide is most evident in, though not exclusively centered on, the split between advocates for the universality of mental disorder classifications and treatments as a crucial basis for ensuring access to care (Patel, 2014), and critics who argue that universal conceptions hinder locally appropriate responses to suffering (Fernando, 2014; Summerfield, 2008). Second, GMH has been dominated by a focus on controlled trials and evaluations of scale-up (Thornicroft & Patel, 2014), which, despite their importance, may at times obscure the insights afforded by other approaches. The papers in this issue contribute to these debates in different ways. Whilst engaging with debates about the cultural appropriateness of GMH, the authors articulate positions that advance beyond a view of GMH as a monolithic field. The papers emphasize the multifaceted nature of GMH, illustrating the varied ways in which global agendas are shaping the strategies and goals of mental health policy and practice. This opens up academic inquiry into global mental health to examine the diverse forms of GMH practice and variety of influences shaping GMH in different places.

The papers also illustrate the different ways in which nuanced ethnographies can contribute to evaluating the achievements of projects linked to GMH, for example in clinical encounters and institutional settings.. This ethnographic work complements existing, more broadly-drawn, conceptual critiques of the field as a whole. Lastly, the papers collected here draw important connections between the local particularities of mental health and wider socio-historical and political processes. In doing so, the papers enhance the evidence base that may potentially inform mental health policy and practice. This introduction will proceed by first discussing key debates over global health mental health, followed by an overview of intersecting issues raised by the papers.

Debates over global mental health

Despite the ethical and economic arguments supporting the GMH project, reservations have been expressed about the goals, methods and outcomes of GMH. These critiques occupy various points across a spectrum spanning from constructive criticism directed at specific aspects of implementation, to stark rejection of foundational assumptions. Among the objections raised by psychiatrists, psychologists and others are the following issues: 1) the project of GMH encourages over-reliance on psychotropic medication as a first-choice response, to the exclusion of alternative therapies (Das & Rao, 2012; Mills, 2014; Orr & Jain, 2015; White & Sashidharan, 2014); 2) the emphasis in GMH on individual pathology potentially distracts attention from other determinants of distress, notably the socio-economic (Das & Rao, 2012; Mills, 2014, 2015; Mills & Fernando, 2014; Mills & White, in press; Tribe, 2014); 3) GMH rests on a model of the self rooted in historically specific values that have limited applicability in many cultures (Bracken, Giller & Summerfield, 2016; Cox & Webb, 2015; Fernando, 2014; Summerfield, 2008; Tribe, 2014); 4) the proclaimed moral imperative to scale up services may be running ahead of the need for pilot studies to ascertain the outcomes of doing so (White & Sashidharan, 2014); 5) the track record of the biomedical paradigm thought by some to dominate GMH does not justify its intensified export throughout the world (Bracken, Giller & Summerfield, 2016; Fernando, 2014; Ingleby, 2014; Mills, 2014; Mills & White, in press; White & Sashidharan, 2014); 6) GMH is weakened by inattention to gender issues (Burgess, 2016); 7) more effort needs to be made to base GMH on the views of people who use services, local communities and local organizations (Mills, 2014; Orr & Jain, 2015; White & Sashidharan, 2014: 8) roll-out of GMH models may be restricting or eliminating other valid forms of healing (Davar,

2014; Fernando, 2014; Sax, 2014). The rejoinders from GMH's spokespersons have not been slow in coming, and have refuted with particular vigour the accusations of promoting the interests of pharmaceutical manufacturers and of psychiatric colonialism (Patel, 2014; see also Whitley, 2015 for an overview of these debates).

This debate has been acerbic at times and perhaps less productive than desirable (Cooper, 2016). Indeed, forums for mutual engagement have often seen participants becoming more entrenched in their positions (see e.g., Bemme & d'Souza, 2012). In part, this reflects incompatibilities in the assumptions that different parties bring with them and an absence of dialectical thinking that might move us on to common ground (Bemme & d'Souza, 2014). Perspectives may vary between and within disciplines as to what constitutes valid evidence, further complicating exchange of ideas. Further, Kohrt and Jallah (2015) make the significant point that many critiques of GMH remain largely theoretical and, fail to engage with the realities of experience of the individuals and families suffering distress. They refer to this phenomenon as the 'experience gap' in scholarship on GMH. There are important exceptions to this observation (closely observed studies that combine incisive critical awareness with a thorough immersion in people's lifeworlds) but Kohrt and Jallah identify the concern that text and theory risk dominating lived experience in these discussions (see also Good, 2010). This is of particular concern when broad generalizations are made about the effects of 'Global Mental Health' as a single entity, rather than as a field with varied activities in diverse settings involving many individuals with different needs, goals and values.

Ethnography and global mental health

While there is a growing body of research evaluating the outcomes of GMH interventions, this work does not easily lend itself to resolving the broader arguments. Advocates of each position often seem to ‘talk past’ each other, bringing incommensurable paradigms to the debate. Good ethnographic research can make a significant contribution to moving beyond this impasse by analysing encounters where the practices of GMH meet diverse social realities and contrasting experiential frameworks. These encounters are the real measure of GMH’s effects in the wide range of settings where its practitioners seek to intervene.

Though ethnographers and other qualitative researchers have a long-standing commitment to mental health research in low and middle-income countries, GMH itself represents a renewed¹ conjuncture of ideas, institutions, arenas for action, and practices for these researchers to address (Kohrt, Mendenhall & Brown, 2015). Challenges to successfully doing so include: 1) the question of how to attempt transnational comparison through localised ethnography in ways that allow wider applicability to GMH as a whole; 2) the priority afforded by influential GMH institutions to demonstrable efficacy through statistical outcome measures in order to facilitate research funding and policy uptake; or, 3) the adoption of value positions by ethnographers that have led some to dismiss GMH out of hand. Perhaps as a result, informative ethnographic research on GMH’s impact is scarce and the potential of ethnographic studies to enhance and possibly reshape the GMH agenda remains largely untapped.

When done well, ethnography has particular strengths, which include: careful attention to the effects of the specific contexts within which interventions are embedded; simultaneous awareness of how practices in a particular time and place are connected to larger economic, political and historical force; and close focus on

the experiential dimensions of the clinical encounter. Ethnographic research also provides some of the most promising avenues for moving beyond the entrenched positions outlined above. The papers in this special issue explore the potential for ethnography to contribute to an understanding of GMH principles, initiatives, strategies and governance, both practically and conceptually.

A recurring theme in all the papers concerns the importance of nuance in evaluating the achievements of GMH projects. The papers demonstrate how close observation and engagement with the field can reveal the dynamics through which mental health policy agendas play out on the ground. This moves scholarship away from seeing GMH-inspired reforms in binaries (e.g. success or failure) or as ‘imposed’ agendas and towards disentangling the power dynamics that shape implementation. For example, Varma (2016) writes about India’s policy of ‘modernizing’ psychiatric institutions, which she links to the goals of the Movement for Global Mental Health (MGMH) and its advocates in India. Based on ethnography of one reform initiative in Kashmir, Varma develops a nuanced picture of the social interests that shape modernization of a particular mental hospital. Her work highlights how a scientific, evidence-based policy vision for the asylum results in foregrounding what is “modern” and “scientific”, while concealing of aspects of the institution that contradict this vision. Burgess’ (2016) ethnography of primary mental health care services in South Africa shows how stigmatizing attitudes held by NGO staff and primary care nurses towards people with mental health difficulties distorted the intended decentralized model of care which was meant to rely on this group of practitioners. She reveals how these attitudes led staff to shift the burden of care onto monthly visits by mental health professionals, thus reducing continuity and access to care.

The contributors to this issue explore key questions for GMH planners and practitioners. Both Sood (2016) and Poltorak (2016) explore a classic theme of ethnography within medical anthropology: What kinds of relationships might be desirable between the biomedical perspectives characteristic of GMH, and co-existing spiritual, traditional or vernacular perspectives? Mindful of the dangers of simplistic dichotomies that Cooper (2016) articulates, they focus on the interactions of biomedical and local knowledge in practice. The contrasts in the case studies are instructive for GMH. Poltorak's subject, Dr. Mappa Puloka, developed a set of strategies that blurred the boundaries between 'Western' biomedical psychiatry and Tongan ways of knowing, reportedly to great effect in reaching the population. In contrast, Sood describes how psychiatric policy's relationship with the Balaji Temple in Rajasthan has been one of confrontation and prohibition. Her article begs the question of how else GMH might engage with medical pluralism without abandoning its commitment to the safety and well-being of people experiencing mental disorder (cf. Orr & Bindi, in press). As Burgess shows in her contribution on clinical encounters planned measures do not always have the effects intended. The insights that her work offers into the gender dynamics of primary mental health care and the limitations of policy in the region of South Africa where she worked point to recommendations for the improvement of practice. Similarly, Varma asks who gets left behind by the dynamism of mental health policy reform and why these areas do not benefit from institutional flows of resources and attention. She shows how GMH-inspired modernizing projects come up against pre-existing networks of stigma and disciplinary prerogatives.

The scope of ethnography is wide and it is practised in varying ways across different settings, responding to the particular requirements of specific research

questions, and to the opportunities and constraints of a particular field-site and the means employed to access it. Just as the papers address GMH in its multiple forms, they also show the relevance of multiple ethnographic approaches to understanding GMH. The notion of temporality is relevant when considering the kinds of ethnography of GMH that are discussed in this collection. While Poltorak's ethnographic account of mental health services' expanding reach in Tonga reflects intermittent but ongoing involvement with a field-site over thirteen years, Burgess argues for the value of the more focused 'motivated ethnography' approach, with fieldwork that can be measured in hours, not months. Poltorak's historically inflected ethnography is able to draw on a wealth of contextual information and interview data across an extended period. However, Burgess shows what value can be obtained from short-term ethnographic work centred on a defined question, in circumstances where urgency or resources do not currently permit more sustained investigation. No doubt caution is called for if truncated ethnography is not to become the norm expected by funders and policy makers, yet the data contributed by such work have value for their own specific purposes.

The contributions by Varma and Sood each draw on periods of fieldwork of intermediate duration and present ethnography of a specific institution: a Kashmiri psychiatric hospital newly designated as a Centre of Excellence, and the Balaji Temple, respectively. Both examine how these distinctive sites are changing under the influence of national policies designed to modernize India's mental health care. Both identify the 'shadow sides' of such processes: Varma through the ethnographic details of those parts of the hospital within the penumbra of the new initiatives and funding flows, Sood by focusing on how the suppression of healing practices found to be unsettling from a modernizing perspective obscures the meaning, value and

therapeutic potential they may hold for those who engage in them. These two authors demonstrate the continuing relevance of single-sited ethnography based in a carefully chosen location to the understanding of larger-scale processes, their contingencies and their exclusions.

As this set of papers illustrates, any ethnographic project requires careful consideration of methods and aims from the outset. When should ethnography be conducted over the long, short, or medium term? When should ethnography emphasise the uncovering of hidden influences from the past, and when should it prioritize what present-day policy is leaving in shadow? When should ethnography be rooted in a single site, and when should it travel in the pursuit of its quarry? When should ethnography be geared towards close-at-hand practice applications, and when should it train its analytical lens on the broad field of 'Global Mental Health' in all its transnational, contested and diverse complexity? Whichever we might individually prioritize, Sara Cooper's paper supplies an important caution against epistemological over-simplification in the course of such studies. Identifying two dominant traditions in transcultural mental health research, which she calls the 'knowledge-belief-practice' and 'indigenous-knowledge-system' approaches, she argues that both are fraught with problems. These issues arise because of the 'either-or' framework within which these models place Western biomedical knowledge about mental health on the one hand, and indigenous African forms of knowledge about mental health (or related concepts) on the other. Cooper finds the solution in a more interactionist and epistemologically sophisticated analysis influenced by Science & Technology Studies (STS), finding its fruition in the kinds of nuanced exploration of people's understandings, values and actions that ethnography at its best can provide.

Concluding comments

Taken together, the papers in this special issue suggest ways that ethnography of GMH can enhance the field. First, the papers in this collection illustrate the value of nuanced ethnographically grounded conceptualizations of global mental health. Cultivating a more diverse set of analyses of GMH's manifestations means focusing on how flows of ideas, knowledge, policies, research and relationships have shaped GMH in different ways in different spaces. This approach recognises that global mental health is in many ways diffuse, shifts form across context and time, and achieves differing degrees of influence in different places (see Ecks, 2016). Importantly, asking 'what is GMH?' potentially contributes to widening policy options to consider diverse forms of practice, whilst also opening up academic inquiry.

Second, the papers suggest that ethnographies need to interrogate GMH approaches through their 'operation' on the ground, including intended and unintended consequences. In enhancing our understanding of the nuances and diversities of GMH, the papers show diverse ways that ethnography can contribute to evaluating the achievements of GMH, with potential policy and practical implications.

Finally, the papers illustrate how an understanding of GMH can be enhanced through the drawing of connections between wider historical, political and social phenomena and local particularities. Some papers highlight how retaining a comparative and historical perspective on GMH offers more potential than a narrow focus on the specific configuration of policies, practice and evidence constituting contemporary GMH. One of ethnography's strengths is its ability to reveal the significance of the social processes that frame its objects of study. Importantly, the

papers in this issue consider what we might call the ‘prehistory’ of GMH to identify the currents that have shaped the ideas underpinning the approach. Both Varma and Sood trace GMH-styled reforms back to the 1990s and early 2000s with the release of the WHO World Health Report 2001. Poltorak’s ethnography also begins before the GMH manifesto was officially drawn up in the form of the Lancet ‘Call to Action’, and unfolds in a country where direct influence of the Movement for Global Mental Health so far appears limited – yet the study’s exploration of how transcultural psychiatry was applied there draws out key lessons for GMH.

Harper and Parker (2006) argue for an ‘anthropology of public health’ concerned with the aims of improving public health and practice whilst maintaining a critical stance that informs interventions by highlighting unintended impacts of policies “for supposed beneficiaries” and studying the “beliefs and practices” professionals (p. 2). An ‘ethnography of global mental health’ must similarly be concerned with improving the mental health of individuals, communities and societies. Yet a critical stance, which subjects the practices of GMH itself to scrutiny, is likewise crucial if ethnographies of global mental health are to make a significant contribution to enhancing the ways in which GMH interventions impact on people's lives. Ultimately, both improvement to GMH approaches and critical interrogation of GMH's methods and assumptions would benefit from a more collaborative dialogue. The detailed examples provided by careful ethnography offer a potentially fruitful basis for this dialogue.

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¹ Though GMH is often presented as ‘new’, partly for the political and academic cachet this claim confers, a historical perspective on long-standing WHO engagement with world mental health shows that its novelty is sometimes exaggerated (Jenkins, 2016). We have therefore preferred to use the term ‘renewed’.